

Wisconsin Department of Safety and Professional Services

Mail To: P.O. Box 8935
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Ship To: 1400 E. Washington Avenue
Madison, WI 53703
E-Mail: dsps@wisconsin.gov
Website: <http://dsps.wi.gov>

BOARD OF NURSING

CERTIFICATION FORM FOR MALPRACTICE INSURANCE COVERAGE FOR NURSE-MIDWIFE

APPLICANT: Complete this section and check the appropriate box(s) by signing and dating this form to certify which of the following applies to you. Please return this form with your completed application (Form #407).

Last Name	First Name	MI	Former / Maiden Name(s)
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Address (number, street, city, zip code)

Application ID # (if applicable)

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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Please check one of the following boxes:

- ☐ I hereby certify that I have malpractice liability insurance coverage in the amount specified in s. 655.23(4), Stats.
- ☐ I am not required to have malpractice insurance coverage because: (check one)
- ☐ I am a federal, state, county, city, village, or town employee who practices nurse-midwifery within the scope of my employment.
- ☐ I am an employee of the federal public health service under 42 U.S.C. s. 233(g).
- ☐ My employer has in effect malpractice liability insurance that provides coverage for me in the amount that is at least the minimum amount specified in Wis. State Stat. § 655.23(4).
- ☐ I do not provide care for patients at this time, but I understand I must have malpractice liability insurance coverage in the amount specified in Wis. State Stat. § 655.23(4) prior to beginning patient care.

Applicant Signature

<input type="text"/>	<input type="text"/>	/	<input type="text"/>	<input type="text"/>	/	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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Date

Return this form directly to the Department at:

DSPS
Attn: Board of Nursing
P.O. Box 8935
Madison, WI 53708-8935

or you may fax/email to 608-261-7083 or DSPS CredNursing@wisconsin.gov.